EMPLOYEE ENROLLMENT GUIDE

Your PEBB Benefits for 2012

Washington State Health Care Authority
Public Employees Benefits Board

Forms Inside

HCA 50-100 (11/11)

Contact the Plans

Medical Plans	Website addresses	Customer service phone numbers	TTY Customer service phone numbers (deaf, hard of hearing, or speech impaired)
Group Health Classic, CDHP, or Value	**www.ghc.org/pebb**	206-901-4636 or 1-888-901-4636	711 or 1-800-833-6388
Kaiser Permanente Classic or CDHP	**www.kp.org**	503-813-2000 or 1-800-813-2000	1-800-735-2900
Uniform Medical Plan Classic or CDHP	**www.ump.hca.wa.gov**	1-888-849-3681	711

Health Savings Account Trustee	Website address	Customer service phone number
HealthEquity, Inc.	**www.healthequity.com/pebb**	1-877-873-8823

Dental Plans	Website addresses	Customer service phone numbers
DeltaCare, administered by Washington Dental Service	**www.deltadentalwa.com/pebb**	1-800-650-1583
Uniform Dental Plan, administered by Washington Dental Service	**www.deltadentalwa.com/pebb**	1-800-537-3406
Willamette Dental	**www.WillametteDental.com/WApebb**	1-855-433-6825

Life Insurance	ReliaStar Life Insurance Company	1-866-689-6990	
Long-Term Disability (LTD) Insurance	Standard Insurance Company	1-800-368-2860	
Flexible Spending Account **Dependent Care Assistance Program**	Application Software Inc. (ASIFlex)	**http://pebb.asiflex.com**	1-800-659-3035
Long-Term Care Insurance	John Hancock Life Insurance Company	**www.pebb.hca.wa.gov/ltc.html**	1-800-399-7271
Auto and Home Insurance	Liberty Mutual Insurance Company	**www.pebb.hca.wa.gov/liberty_mutual.html**	1-800-706-5525

Contact the plans for help with:

- Specific benefit questions.
- Verifying if your doctor or other provider contracts with the plan.
- Verifying if your medications are in the plan's drug formulary.
- ID cards.
- Claims.

Contact your employer for help with:

- Changing your name, address, and phone number.
- Finding forms.
- Adding or removing dependents.
- Payroll deduction information.
- Eligibility complaints or appeals.
- Life and LTD insurance eligibility and enrollment questions.
- Eligibility questions and changes (Medicare, divorce, etc).

Contact the PEBB Program at 1-800-200-1004 for help with:

- Eligibility complaints or appeals (after contacting your employer first).

Blue ink indicates information only for subscribers who have PEBB dental coverage.

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To obtain this document in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2714. TTY users may call through the Washington Relay Service by dialing 711.

Blue ink indicates information only for subscribers who have PEBB dental coverage.

Glossary

Annual deductible
The amount you must pay each calendar year before the plan pays for covered benefits. The annual deductible does not apply to some benefits. See your plan's certificate of coverage for details.

Annual out-of-pocket maximum
The most you would pay toward the majority of covered expenses in a calendar year. This means once you've reached your out-of-pocket maximum, the plans pay 100 percent of most covered expenses for the rest of the calendar year. The annual out-of-pocket maximum varies by plan. See your plan's certificate of coverage for details.

Certificate of coverage (COC)
A legal document that describes eligibility, covered services, limitations and exclusions, and other details specific to a health plan. A certificate of coverage is available upon request from the medical or dental plan after you enroll.

Coinsurance
The percentage you pay of your plan's allowed charges from a provider when the plan pays less than 100 percent.

Copay
The fixed cost you pay for services at the time you receive care. Most plans described in this guide require a copay when you see a provider or receive prescription drugs.

Creditable coverage
Health coverage that you had in the past that gives you certain rights when you apply for new coverage. PEBB health plans offer creditable coverage.

Drug formulary
Some plans call this a preferred drug list. The formulary lists approved prescription drugs that the plan will cover. Each plan has a different formulary and can make its list available to you.

HCA
The Health Care Authority (HCA) is the state agency that develops and administers health insurance programs for state and higher-education employees, retirees, and their dependents, as well as other eligible groups that choose to purchase Public Employees Benefits Board (PEBB) coverage. The HCA provides medical, dental, life, and long-term disability insurance coverage to eligible enrollees, and offers a flexible spending account, Dependent Care Assistance Program, auto and home insurance, and long-term care insurance through the PEBB Program.

Maximum plan payment
Some health plans have limits on how much they will pay for covered services, as detailed in each health plan's certificate of coverage.

Network
A group of health care providers (including doctors, hospitals, and other health care professionals and facilities) who have contracted to provide services to a health plan's members at negotiated rates.

Premium
The amount PEBB members pay monthly for the cost of their health coverage. Premiums vary in cost depending on the health plan and the number of family members enrolled.

Provider
A health care practitioner or facility.

WAC
The rules that the Public Employees Benefits Board (PEBB) Program follows are called the Washington Administrative Code (WAC).

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Welcome

We want you to have confidence in knowing that your and your family's well-being is important to your employer. That's why your employer provides health coverage through the Public Employees Benefits Board (PEBB) Program, administered by the Washington State Health Care Authority (HCA). This benefits package provides you (the subscriber) with insurance coverage that delivers choice, access, value, and stability.

The HCA purchases and coordinates health insurance benefits for eligible employees and retirees, so you can expect to receive competitive benefits from one of the largest health-care purchasers in the state.

If you are a state agency or higher-education employee, you have medical and dental coverage, life insurance, long-term disability insurance, and the option to enroll in a medical flexible spending account (FSA) and the Dependent Care Assistance Program (DCAP). If you are employed by a school district, county or city government, or other employer group, your employer may offer PEBB medical only or PEBB medical, dental, life, and long-term disability insurance. The PEBB Program also provides access to long-term care insurance and auto and homeowners' insurance. The FSA and DCAP are not available to employer groups through PEBB. Check with your payroll, personnel, or benefits office to find what coverage your employer offers and what you may qualify for.

Look inside to find. . .

- Eligibility and enrollment information.
- Basic information about your medical and dental coverage, to help you make health plan decisions.
- Information about basic life and long-term disability (LTD) insurance, as well as optional life and LTD insurance you may purchase.
- Optional benefits—auto, home, and long-term care insurance, as well as the FSA and the DCAP.

If you have questions not answered in this booklet, please contact your employer's personnel, payroll, or benefits office or visit PEBB's website at **www.pebb.hca.wa.gov**.

Who determines the benefits?

The Legislature establishes how much state money is available to spend on employee benefits. Then the PEB Board establishes eligibility requirements and approves the benefit designs for insurance and other benefits. The Board meets regularly to review benefit and eligibility issues, and plan for the future.

Who purchases the benefits?

The Health Care Authority (HCA) purchases benefits within the amount of money funded by the Legislature. The HCA contracts with insurance companies and manages its own self-insured plans—the Uniform Medical Plan and Uniform Dental Plan—to provide a choice of quality health care options and responsive customer service to its members.

Who administers the benefits?

The HCA's PEBB Program administers benefit eligibility and enrollment.

Benefits disclaimer
The benefits described in this guide are brief summaries. For a complete description of PEBB benefits, refer to the health plan's certificate of coverage. (See the "Glossary" for definition.) Your plan's certificate of coverage will be available to you, either on your health plan's website or by calling the plan to request one. Some benefits described in this guide are based on federal or state laws. We have attempted to describe them accurately as of the time of printing, but if there are differences, the laws will govern.

PEBB laws and rules
You may find the Public Employees Benefits Board's existing law in chapter 41.05 of the Revised Code of Washington (RCW), and rules in chapters 182-04, 182-08, 182-12, 182-13, and 182-16 of Washington Administrative Code (WAC). These are available on the Office of the Code Reviser's website at **www.leg.wa.gov/CodeReviser/Pages/default.aspx** and on the PEBB website at **www.pebb.hca.wa.gov**.

PEBB Program is Saving the Green

Help reduce our reliance on paper mailings—and their toll on the environment—by signing up to receive PEBB mailings by email. To sign up, go to **www.pebb.hca.wa.gov** and select *My Account* under the *Coverage* header in the left navigation panel.

Eligibility Summary

Who's eligible for PEBB coverage?

For complete details on PEBB eligibility and enrollment, refer to Washington Administrative Code (WAC), chapter 182-12. You can find these in the *PEBB Rules and Policies* section at www.pebb.hca.wa.gov.

Your employer will determine if you are eligible for PEBB health coverage based on your specific employment circumstances, and whether you qualify for the employer contribution (see WAC 182-12-114 and 182-12-131). If you disagree with their determination, see "How can I appeal a decision?" on page 7.

Employees

Employees (referred to in this booklet as "employees," "subscribers," or in some cases, "enrollees") are eligible for PEBB benefits if they work an average of at least 80 hours per month and at least eight hours in each month for more than six consecutive months.

Faculty

Faculty are eligible for PEBB benefits if the employer anticipates they will work half-time or more for the entire instructional year or equivalent nine-month period.

If the employer doesn't anticipate that the faculty will work the entire instructional year or equivalent nine-month period, then faculty are eligible for PEBB benefits at the beginning of the second consecutive quarter or semester of employment, if the faculty are anticipated to work (or has actually worked) at least half-time or more. (Spring and fall are considered consecutive quarters/semesters when first establishing eligibility for faculty that work less than half-time during the summer quarter/semester.)

Faculty may continue any combination of medical, dental, and life insurance coverage during periods when they are not eligible for the employer contribution by self-paying for the benefits. See WAC 182-12-142 for continuation coverage information.

Seasonal employees

Seasonal employees are eligible if they work an average of at least 80 hours per month and for at least eight hours in each month of the season. (A season is any recurring, cyclical period of work at a specific time of year that lasts three to 11 months.) See WAC 182-12-114(2) for details on when a seasonal employee becomes eligible.

A benefits-eligible seasonal employee who works a season of nine months or more is also eligible for the employer contribution through the off season following each season worked. A benefits-eligible seasonal employee who works a season of less than nine months is not eligible for the employer contribution during the off season, but may continue enrollment between periods of eligibility for a maximum of 12 months by self-paying for the benefits. See WAC 182-12-142 for continuation coverage information.

Elected and appointed officials

Legislators are eligible for PEBB benefits on the date their term begins. All other elected and full-time appointed officials of the legislative and executive branches of state government are eligible on the date their terms begin or the date they take the oath of office, whichever occurs first.

Justices and judges

A justice of the supreme court and judges of the court of appeals and the superior courts become eligible for PEBB benefits on the date they take the oath of office.

Can I cover my family members?

You may enroll the following family members (referred to in this booklet as "family members" or "dependents"):

- Your lawful spouse.
- Your Washington State-registered domestic partner. The Washington State registry includes opposite-sex domestic partners in which at least one partner is age 62 or older, and same-sex domestic partners.
- Your children, defined as your biological children, stepchildren, legally adopted children, children for whom you have assumed a legal obligation for total or partial support in anticipation of adoption, children of your Washington State-registered domestic partner, or children specified in a court order or divorce decree.

  In addition, children include extended dependents in your, your spouse's, or your Washington State-registered domestic partner's legal custody or legal guardianship. Legal responsibility is shown by a valid court order and the child's official residence with the custodian or guardian. Children do not include foster children for whom support payments are made to you through the state Department of Social and Health Services' (DSHS) foster care program.

Blue ink indicates information only for subscribers who have PEBB dental coverage.

Eligible children include:

- Children up to age 26.
- Children of any age with a disability, provided the child is incapable of self-support and the disability, mental illness, intellectual or other developmental disability occured before age 26. The PEBB Program certifies dependents with disabilities periodically beginning at age 26.

  Children ages 26 and older who become capable of self-support do not regain eligibility as a child with a disability if they later become incapable of self-support.

The PEBB Program may require proof of eligibility before your dependent will be enrolled or for any enrolled dependent

You must notify your employing agency in writing no later than 60 days after your dependent is no longer eligible.

How can I appeal a decision?

If you or your dependent disagrees with a specific decision or denial related to eligibility or enrollment, you or your dependent may file an appeal. You must submit your appeal **no later than 30 days** from the date of the decision or action you are appealing. You may find guidance on filing an appeal in WAC 182-16-025 and at **www.pebb.hca.wa.gov** under *How Do I File an Appeal*, or call the PEBB Appeals Manager at 1-800-351-6827.

If you are seeking a review of a decision or action by a health plan or insurance carrier about a claim or benefit (such as a dispute about a course of treatment or billing), contact the health plan or insurance carrier to request information on how to appeal its decision or action.

Enrollment

For complete details on PEBB enrollment, refer to chapters 182-08 and 182-12 WAC. You can find these in the *PEBB Rules and Policies* section on PEBB's website at www.pebb.hca.wa.gov.

How do I enroll?

To enroll in PEBB employee coverage, follow these steps:

1. Ask your personnel, payroll, or benefits office if your employer offers PEBB medical, dental, life, and long-term disability insurance coverage, or medical only. State agencies and higher-education institutions offer PEBB medical, dental, life, and long-term disability insurance coverage, but some school districts, city and county governments, and other employer groups offer PEBB medical only.
2. Check "Medical Plans Available by County" on pages 20–21 to find which medical plans are offered in your county of residence.
3. Read about the types of medical and dental plans that PEBB offers. See "How the Medical Plans Work" on pages 18–19. If your employer also offers PEBB dental coverage, see "How the Dental Plans Work" on page 24. Call the plans directly with questions about specific benefits or drugs they cover. The health plan phone numbers and website addresses are listed on page 2.
4. Compare medical plans' monthly premiums under "2012 Monthly Premiums" on page 17. (There are no employee premiums for dental coverage for state and higher-education employees.)
5. Check the provider directory on each plan's website to find out if your provider participates with the medical and/or dental plan you choose. You may also call the plan directly to confirm your provider's participation. If you choose a new provider, ask if he or she is accepting new patients. Each family member may have a different doctor or other health care provider.
6. Complete the *Employee Enrollment/Change* form (if you have both medical and dental coverage) or the *Employee Enrollment/Change Form for Medical Only Groups* (if you have medical coverage only) found in the back of this guide. Select the medical and/or dental plans you choose.
7. If you enroll family members on your PEBB coverage, you must provide proof of eligibility within PEBB's enrollment timelines or the family members will not be enrolled. A list of documents we will accept as proof is on page 34.
8. If you enroll the family members shown in the box below, you must also complete the appropriate forms.
9. Complete and return the form(s) to your personnel, payroll, or benefits office **no later than 31 days** after the date you become eligible for PEBB benefits. (Generally, an employee becomes eligible the first day of employment; ask your personnel, payroll, or benefits office when your eligibility begins.)

If you don't submit the completed form(s) and verification documents for your dependents (if needed) within 31 days, we will enroll you in Uniform Medical Plan (UMP) Classic and Uniform Dental Plan (UDP) (if your employer offers PEBB dental coverage) as a single subscriber. You cannot change plans or enroll your eligible dependents until the next annual open enrollment, or if you have a special open enrollment event.

ID Cards

After you enroll, your plan(s) will send you an identification (ID) card to show providers when you receive care.

If you have questions about your ID card, contact your plan directly.

(The Uniform Dental Plan does not mail ID cards.)

Can I enroll on two PEBB accounts?

If you and your spouse or Washington State-registered domestic partner are both eligible for PEBB coverage, you need to decide which of you will cover yourselves and any eligible children on your medical and/or dental plan. A family member may be enrolled in only one medical or dental plan. This means you could waive medical coverage for yourself and enroll on your spouse's or domestic partner's medical coverage. However, you must enroll in dental coverage under your account.

If enrolling a...	...then complete this form
Washington State-registered domestic partner (or a domestic partner's child)	*Declaration of Tax Status*
Dependent child with a disability	*Certification of Dependents With Disabilities*
Extended (legal) dependent child	*Extended Dependent Certification*
Forms are available at www.pebb.hca.wa.gov or through your employer's personnel, payroll, or benefits office.	

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When does coverage begin?

When newly eligible—Medical, dental, basic life, and basic long-term disability (LTD) insurance coverage begins on the first day of the month after an employee becomes eligible (generally the first day of employment). If the employee becomes eligible on the first working day of the month, these PEBB benefits begin on that day.

For faculty hired on a quarter/semester to quarter/semester basis, medical, dental, basic life and basic LTD insurance begins the first of the month after the beginning of the second consecutive quarter/semester of half-time or more employment. If the first day of the second consecutive quarter/semester is the first working day of the month, these PEBB benefits begin on that day.

When making a change during annual open enrollment or when a special open enrollment event occurs—Coverage will begin as noted in the table below. You must submit the appropriate form(s) and proof of your dependent's eligibility during the annual open enrollment or **no later than 60 days** after the special open enrollment event. See "What is a special open enrollment?" on page 12 for more information and examples of special open enrollment events.

Annual event	When coverage begins
Open enrollment	Medical coverage for an employee (who previously waived medical coverage) and his or her eligible, verified family members starts January 1 of the following year.
Special open enrollment event	**When coverage begins**
Marriage or establishment of a Washington State-registered domestic partnership	The first of the month after the date of the event or the date your personnel, payroll, or benefits office receives your completed enrollment form, whichever is later.
Birth or adoption	The date of birth (newborns) or the date you assume legal obligation for the child's support in anticipation of adoption. If the child's date of birth or adoption is before the 16th day of the month, you pay the full month's premium (if adding the child increases the premium). If the child's date of birth or adoption is on or after the 16th, the higher premium will begin the next month. If you add other eligible family members to your PEBB coverage due to birth or adoption, their medical coverage begins the first of the month in which the birth or adoption occurs. Supplemental life insurance for newborns (if elected) begins on the 14th day.
Child becomes eligible as a dependent with a disability, or an extended dependent	The first of the month after eligibility certification.
You or a family member loses other coverage under a group health plan or through health insurance (as defined by HIPAA)	The first of the month after the date of the event or the date your personnel, payroll, or benefits office receives your completed enrollment form, whichever is later.
You or a family member has a change in employment status that affects eligibility for the employer contribution toward group health coverage	The first of the month after the date of the event or the date your personnel, payroll, or benefits office receives your completed enrollment form, whichever is later.
You or a family member gains or loses eligibility for state premium assistance through Medicaid or Children's Health Insurance Program	The first of the month after the date of the event or the date your personnel, payroll, or benefits office receives your completed enrollment form, whichever is later.

Enrollment

What if I'm entitled to Medicare?

Medicare Parts A and B

When you or your covered dependents become entitled to Medicare, the person entitled to Medicare should contact the nearest Social Security office to ask about the advantages of immediate or deferred Medicare enrollment.

For employees and their enrolled spouses ages 65 and older, the PEBB medical plan provides primary insurance coverage, and Medicare coverage is secondary. However, you may choose to reject the PEBB medical plan and choose Medicare as your primary insurer. **If you want Medicare as your primary coverage, you must notify the PEBB Program in writing.** You can reenroll in a PEBB medical plan during a special open enrollment or annual open enrollment. However, you will remain enrolled in PEBB dental, life, and long-term disability insurance coverage.

Medicare guidelines direct that qualified/Washington State-registered domestic partners who are age 65 or older must have Medicare as their primary insurer.

Medicare Part B

In most situations, employees and their spouses can elect to defer Medicare Part B enrollment, without penalty, up to the date the employee terminates employment or retires. If your entitlement is due to a disability, contact your Social Security office regarding deferred enrollment. If you retire and are eligible for PEBB retiree coverage, you must enroll in Medicare Parts A and B, if entitled. Medicare will become the primary insurer, and the PEBB medical plan becomes secondary.

Contact your nearest Social Security office for information on deferring or reinstating Medicare Part B.

Medicare Part D

Medicare Part D is available to people enrolled in Medicare Part A and/or Part B. It is a voluntary program that offers prescription-drug benefits through private plans. These plans provide at least a standard level of coverage set by Medicare.

All PEBB medical plans have prescription-drug coverage that is as good as or better than the standard Medicare Part D coverage. This means that after you become entitled to Medicare Part A and/or B, you can keep your PEBB coverage and not pay a late enrollment penalty if you decide to enroll in a Medicare Part D plan later.

If you choose to enroll in Medicare Part D, your PEBB medical plan may not coordinate prescription-drug benefits with your Medicare Part D plan.

How much do the plans cost?

Please see the "2012 Monthly Premiums" on page 17.

In addition to your monthly premium, you must pay for any deductibles, coinsurance, or copayments under the plan you choose. See the certificate of coverage available from each plan for details. Your employer charges and collects premiums for the full month, and will not prorate them for any reason, including when a member dies before the end of the month.

How do I pay for coverage?

Eligible state agency and higher-education institution employees may pay medical premiums with pre-tax dollars from their salary under the state's premium payment plan. Internal Revenue Service code Section 125 allows your employer to deduct money from your paycheck before calculating certain payroll taxes and your income tax. If you are not a state agency or higher-education employee, ask your employer's personnel, payroll, or benefits office if they offer this benefit.

Why should I pay my monthly premiums with pretax dollars?

You take home more money because taxes are calculated after the premium and/or contributions are deducted. This reduces your taxable income, which lowers your taxes and saves you money.

Do I need to complete a form to have my medical premium payments withheld pretax?

No. If you are a new employee who enrolls in a medical plan, and your employer offers this benefit, your payroll office will automatically have the premiums deducted before calculating taxes. If you do not want to pay your medical premiums with pretax earnings, you must complete and submit a *Premium Payment Plan Election/Change Form* to decline (opt out of) participation in the premium payment plan **no later than 31 days** after you become eligible for PEBB benefits (generally the first day of employment; see WAC 182-12-114). The waiver form is available from your personnel, payroll, or benefits office.

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Can I change my mind about having my medical premium payments withheld pretax?

You may only change your participation under the state's premium payment plan (enroll, decline enrollment, or change election) during an annual open enrollment or a special open enrollment as described in WAC 182-08-199.

When would it benefit me not to have a pretax deduction?

If you have your medical premiums deducted pretax, it may also affect the following benefits:

- **Social Security—**If your base salary is under the $110,100 annual maximum, Section 125 participation saves you money now by reducing your Social Security taxes. However, your lifetime social security benefit would be calculated using the lower salary.
- **Unemployment compensation—** Section 125 also reduces the base salary used to calculate unemployment compensation.

To learn more about Section 125, talk to a qualified financial planner or your local Social Security office.

PEBB forms and frequently asked questions and answers are available on our website at **www.pebb.hca.wa.gov.**

Making Changes in Coverage

How do I add or remove dependents?

You may enroll your eligible dependents when you enroll in a PEBB medical and/or dental plan. You must return the *Employee Enrollment/Change* form indicating the dependent's enrollment to your personnel, payroll, or benefits office **no later than 31 days** after the date you become eligible for PEBB benefits. If enrolling a dependent with a disability or an extended dependent, you must also submit a dependent certification form.

To add an eligible dependent, you must also provide copies of documents that verify the dependent's eligibility with your enrollment form within PEBB's enrollment timelines or the dependent will not be enrolled. A list of documents we will accept as proof is available on page 34. The PEBB Program can also remove your enrolled dependent from health plan enrollment if it can't verify your dependent's eligibility within a specified time.

You can also add eligible dependents during an annual open enrollment or if there is a qualifying event that allows for a special open enrollment. (See "What is a special open enrollment?" on this page.)

To remove a dependent from your account, you must return the *Employee Enrollment/Change* form to your personnel, payroll, or benefits office **no later than 60 days** after the date the dependent no longer meets PEBB's eligibility criteria. You may also remove eligible dependents from your account during an annual open enrollment. (See "What happens when a dependent loses eligibility?" on page 14.)

Your coverage is for an entire year (January 1 through December 31), unless you make changes due to a special open enrollment event or are no longer eligible under PEBB rules.

What changes can I make during open enrollment?

You may make changes to your enrollment during any annual open enrollment as long as you submit these changes before the end of the enrollment period. During the annual open enrollment, you can:

- Enroll in or waive enrollment in a medical plan;
- Enroll or remove eligible dependents;
- Enroll or reenroll in a medical flexible spending account (PEBB benefits-eligible state agency and higher-education employees only);
- Enroll or reenroll in the Dependent Care Assistance Program (PEBB benefits-eligible state agency and higher-education employees only);
- Change medical or dental plans; or
- Change your election under the state's premium payment plan (see "How do I pay for coverage?" on page 10).

You must submit the appropriate form(s) to your personnel, payroll, or benefits office no later than the end of the annual open enrollment (usually November 30). The enrollment change will become effective January 1 of the following year.

What is a special open enrollment?

You may change your enrollment outside of the annual open enrollment if a special open enrollment event occurs. However, the Internal Revenue Code (IRC) must allow the change and it must correspond to the event that creates the special open enrollment for either you or your dependent (or both).

An eligible qualifying event must occur to create a special open enrollment that allows you to make one of the following changes and make a corresponding change to your election under the premium payment plan:

- Enroll or remove eligible dependents.
- Enroll in, change, or waive enrollment in a medical plan.
- Change dental plans.
- Enroll after waiving medical coverage.

To make an enrollment change, you must submit the appropriate form(s) to your personnel, payroll, or benefits office **no later than 60 days** after the event that created the special open enrollment. In addition to the appropriate forms, your employer may require you to prove eligibility or provide evidence of the event that created the special open enrollment.

Exception: If you want to enroll a newborn or child whom you have adopted (or have assumed a legal obligation for total or partial support in anticipation of adoption), you should notify your employer by submitting an *Employee Enrollment/Change* form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, you **must** submit the *Employee Enrollment/Change* form no later than 12 months after the date of birth, adoption, or the date the

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legal obligation is assumed for total or partial support in anticipation of adoption.

Qualifying events that create a special open enrollment

Any one of the following events may create a special open enrollment to enroll or remove a dependent, change your medical and/or dental plan, waive medical plan coverage, and/or enroll after waiving medical plan coverage.

- Employee acquires a new dependent due to:
  - Marriage or registering a domestic partnership with Washington's Secretary of State.
  - Birth, adoption, or when a subscriber has assumed a legal obligation for total or partial support in anticipation of adoption.
  - A child becoming eligible as an extended dependent through legal custody or legal guardianship.
  - A child becoming eligible as a dependent with a disability.
- Employee or a dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- Employee or a dependent has a change in employment status that affects the employee's or the dependent's eligibility for the employer contribution toward group health coverage.
- Employee receives a court order or medical support order requiring the employee, the employee's spouse, or the employee's Washington State-registered domestic partner to provide insurance coverage for an eligible dependent. A former spouse or former registered domestic partner is not an eligible dependent.
- Employee or a dependent becomes eligible for state premium assistance through Medicaid or the state Children's Health Insurance Program (CHIP), or the employee or dependent loses eligibility under Medicaid or CHIP.

Additional qualifying events for changing plans

Any one of the following events may create a special open enrollment for an employee to change his or her plan(s).

- Employee or a dependent has a change in residence that affects health plan availability. If the employee moves and the employee's current health plan is not available in the new location, the employee must select a new health plan. If the employee does not select a new health plan, the PEBB Program may change the employee's health plan as described in WAC 182-08-196.
- Employee or dependent becomes entitled to Medicare, or enrolls in or disenrolls from a Medicare Part D plan. If the employee's current health plan becomes unavailable due to the employee's or a dependent's entitlement to Medicare, the employee must select a new health plan as described in WAC 182-08-196.
- Employee or a dependent's current health plan becomes unavailable because the employee or enrolled dependent is no longer eligible for a health savings account (HSA). The PEBB Program may require evidence that the employee or dependent is no longer eligible for an HSA.
- Employee experiences a disruption that could function as a reduction in benefits for the employee or the dependent(s) due to a specific condition or ongoing course of treatment. An employee may not change his or her health plan if the employee's or an enrolled dependent's physician stops participation with the employee's health plan unless the PEBB Program determines that a continuity of care issue exists. The PEBB Program criteria used will include, but is not limited to, the following:
  - Active cancer treatment; or
  - Recent transplant (within the last 12 months); or
  - Scheduled surgery within the next 60 days; or
  - Major surgery within the previous 60 days; or
  - Third trimester of pregnancy; or
  - Language barrier.

Out-of-area coverage

Each plan administers coverage differently for services received outside of the plan's service area (such as for a child who is attending school out-of-state, or when you are on vacation). Contact your plan or refer to their certificate of coverage for details.

Making Changes in Coverage

What happens when a dependent loses eligibility?

You **must** complete and submit an *Employee Enrollment/Change* form to your personnel, payroll, or benefits office to remove a dependent from your account **no later than 60 days** after the date the dependent no longer meets PEBB's eligibility criteria. Your dependent will be removed from coverage on the last day of the month in which he or she ceases to meet the eligibility criteria.

If you don't notify your employer's personnel, payroll, or benefits office **within 60 days** after your dependent loses eligibility, or if a dependent's eligibility cannot be verified, the dependent will be removed from health plan enrollment. Consequences may also include, but are not limited to:

- The dependent may lose eligibility to continue health plan coverage under one of the continuation options described on page 16.
- The subscriber may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility.
- The subscriber may not be able to recover subscriber-paid insurance premiums for dependents who lost eligibility.
- The subscriber may be responsible for premiums paid by the state for a dependent's health plan coverage after the dependent lost eligibility.

When can I change my election in the FSA or DCAP?

Once you enroll in an FSA or DCAP, you cannot make changes to your election(s) during the plan year unless you have a qualifying event (see WAC 182-08-199 for details). The requested change must correspond to and be consistent with the qualifying event. If you have a qualifying event, you must complete and submit a *Change of Election Form* **within 60 days** of the date of the qualifying event and return it to ASIFlex for processing. ASIFlex will not approve requests received more than 60 days after your qualifying event. The change to your FSA or DCAP will begin on the first of the month after ASIFlex approves your request.
For more information about making a change, see the appropriate *Enrollment Guide* by selecting *Forms & Documents* at **http://pebb.asiflex.com.**

Waiving Medical Coverage

If you are a state agency or higher-education employee who is eligible for PEBB benefits, you cannot waive dental, basic life, and basic long-term disability insurance for yourself. Employees may waive PEBB medical coverage if they are enrolled in other comprehensive group medical coverage. **If you waive coverage for yourself, you cannot enroll your eligible dependents in PEBB medical coverage.**

To waive medical coverage, you must submit a completed *Employee Enrollment/Change* form to your employer indicating that you want to waive enrollment **no later than 31 days** after the date you become eligible for PEBB benefits (this is generally the first day of employment), or during an annual or special open enrollment as described on pages 12-13.

Once you waive PEBB coverage, you may reenroll by submitting a completed *Employee Enrollment/Change* form to your personnel, payroll, or benefits office during an annual open enrollment or **no later than 60 days** after a special open enrollment event that allows for enrollment. The PEBB Program may require you to provide proof of eligibility and proof of the event that creates a special open enrollment.

For more information, see WAC 182-12-128.

When Coverage Ends

When does PEBB coverage end?

PEBB coverage ends as follows:

- When you or a dependent loses eligibility for PEBB benefits, coverage ends at midnight on the last day of the month in which eligibility ends or the member does not comply with PEBB procedures to provide information by a deadline, as allowed by state and federal laws.

  If an enrollee dies before the end of the month, premium payments are not prorated.

- When you or a dependent declines the opportunity, is ineligible for, or chooses not to continue enrollment in a PEBB medical plan under one of the options for continuing PEBB benefits, then coverage ends at midnight on the last day of the month in which you or your dependent loses eligibility under PEBB rules.

- If an enrollee or newborn eligible for benefits under obstetric and newborn care is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB coverage ends, and the enrollee is not immediately covered by other health care coverage, the employer contribution to insurance coverage will be extended in certain circumstances. Refer to your plan's certificate of coverage for details.

What are my options when coverage ends?

You, your dependents, or both may temporarily continue your PEBB coverage by self-paying the premiums, with no contribution from your employer, after your eligibility ends (including if you die). Options for continuing coverage vary based on the reason you lost eligibility. The PEBB Program will mail a *Continuation of Coverage Election Notice* booklet to you or your dependent when employer-paid coverage ends. This booklet further explains the options listed below, and includes enrollment forms to apply for continuation coverage.

You or your eligible family members must apply to continue your coverage **no later than 60 days** after the postmark on the *Continuation of Coverage Election Notice* booklet, or you will lose all rights to continue PEBB coverage.

There are four possible continuation coverage options you and your eligible family members may qualify for:

1. COBRA
2. PEBB Extension of Coverage
3. Leave Without Pay (LWOP) coverage
4. PEBB retiree coverage

The first three options temporarily extend PEBB health coverage in certain circumstances when you would otherwise lose medical and dental coverage.

COBRA eligibility is defined in federal law and governed by federal rules.

PEBB Extension of Coverage is an alternative created for PEBB enrollees who are not eligible for COBRA.

LWOP coverage is an alternative that may be appropriate in specific situations.

PEBB retiree coverage is available only to individuals who meet eligibility and procedural requirements in WAC 182-12-171 or surviving dependents who meet eligibility requirements in WAC 182-12-250 or 182-12-265. You can find these rules in the *PEBB Rules and Policies* section of PEBB's website at **www.pebb.hca.wa.gov**.

The PEBB Program administers all four continuing coverage options. Refer to your *PEBB Initial Notice of COBRA and Continuation Coverage Rights* booklet (mailed to you after you enroll in PEBB coverage) for specific details or call the PEBB Program at 1-800-200-1004.

What happens to my FSA when coverage ends?

Participation in the FSA typically ends when your employment ends or you go on unpaid leave that is not approved under the Family and Medical Leave Act (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA). This means you can claim expenses, up to your available funds, incurred during your employment but generally, you cannot claim any expenses incurred after you leave employment unless you continue your coverage under COBRA. If you are eligible to continue coverage under COBRA (see WAC 182-12-133), you may extend your period of coverage so you may claim expenses incurred after your employment ends or your unpaid leave begins. To continue your participation in the FSA, you must elect to continue coverage through ASIFlex **within 60 days** of the event that ends your employment or begins your unpaid leave. If you elect to continue your FSA coverage, your contributions will be made on a post-tax basis. Please contact ASIFlex at 1-800-659-3035 or send an email to **asi@asiflex.com** for more information.

Blue ink indicates information only for subscribers who have PEBB dental coverage.

2012 Monthly Premiums

For state agency and higher-education employees

School district employees and those who work for a city, county, port, water district, hospital, etc., need to contact their personnel, payroll, or benefits office to get their monthly premiums.

PEBB Medical Plans	Employee	Employee & Spouse*	Employee & Child(ren)	Full Family
Group Health Classic	$101	$212	$177	$288
Group Health Consumer-Directed Health Plan	26	62	46	82
Group Health Value	52	114	91	153
Kaiser Permanente Classic	89	188	156	255
Kaiser Permanente Consumer-Directed Health Plan	24	58	42	76
Uniform Medical Plan Classic, administered by Regence BlueShield	82	174	144	236
UMP Consumer-Directed Health Plan	27	64	47	84

*or qualified/Washington State-registered domestic partner

How the Medical Plans Work

How can I compare the plans?

All medical plans offer the same basic benefits, although benefit enhancements, limitations, premiums, annual deductible, copays, coinsurance, and out-of-pocket maximums may vary. For example, the consumer-directed health plans (CDHPs) have the lowest monthly premiums, but they also have higher annual deductibles and higher out-of-pocket maximums. You can decide which plan makes the most sense for you and your family.

If you cover eligible dependents, they must be covered under the same medical and dental plans you choose.

As you review the plans, here are some things to consider:

- **Geography.** In most cases, you must live in the plan's service area to join the plan. See "Medical Plans Available by County" on pages 20–21. Be sure to contact the plan(s) you're interested in to ask about provider availability in your county.
- **Cost.** Premiums vary by plan. Keep in mind, higher cost doesn't necessarily mean higher quality of care or better benefits; each plan has the same basic level of benefits. The Public Employees Benefits Board sets the premiums for state agency and higher-education employees, based on funding from the Legislature. **If you are employed by a school district, city, county, port, water district, hospital, or other employer group, contact your payroll, personnel, or benefits office to find out your monthly premium.**
- **Special medical needs.** If you or a dependent needs certain medical care, you may want to choose a plan that provides the optimum benefits and coverage for the needed treatment, medications, or equipment. **Note:** Each plan has a different formulary, which is a list of approved prescription drugs the plan will cover.
- **Coinsurance vs. copays.** PEBB's classic and value managed-care plans require you to pay a fixed portion called a "copay" and/or a coinsurance (percentage of an allowed fee) when you receive network care. UMP Classic and the CDHPs require members to pay coinsurance.
- **Deductible.** All medical plans require you to pay an annual deductible before the plan pays for covered services. UMP Classic also has a separate annual deductible for prescription drugs. Preventive care and certain other benefits are exempt from the medical plans' deductibles.
- **Out-of-pocket maximum.** This is the maximum amount you pay in one calendar year. Once you have paid this amount, most plans pay 100 percent of allowed charges for a majority of covered services for the remainder of the calendar year. The out-of-pocket maximum varies by plan.
- **Referral procedures.** Some plans allow you to self-refer to any network provider; others require you to have a referral from your primary care provider. All plans allow self-referral to a participating provider for women's health care services.
- **Your provider.** If you have a long-term relationship with your doctor or health-care provider, you should verify whether he or she is in the plan's network before you join by calling the provider or plan directly.

  Your family members may select the same provider, but it's not required. Each family member may select his or her own provider available through the plan.

  After you join a plan, you may change your provider although the rules vary by plan.
- **Paperwork.** In general, PEBB plans don't require you to file claims. However, UMP Classic members may need to file a claim if they receive services from a non-network provider. CDHP members may also file claims to receive reimbursement from their health savings account.
- **Coordination with your other benefits.** If you are also covered through your spouse's or domestic partner's comprehensive group health coverage, call the medical and/or dental plan(s) directly to ask how they will coordinate benefits. Coordinating your PEBB plan's benefits with your other plan's benefits may save you money. (**Note:** If you have other comprehensive health coverage, you may not enroll in a consumer-directed health plan with a health savings account. Call HealthEquity at 1-877-873-8823 to ask about certain exceptions.)

Questions? Contact the medical plans directly. Their phone numbers and websites are listed on the inside front cover.

Blue ink indicates information only for subscribers who have PEBB dental coverage.

Want more help making a medical plan choice?

You can compare medical plans side-by-side at PEBB's website at **www.pebb.hca.wa.gov.** You can also visit the medical **and dental** plans' websites to find participating providers and more detailed information.

Medical Plans Available by County

In most cases, you must live in the medical plan's service area to join the plan. Be sure to call the plan(s) you are interested in to ask about provider availability in your county.

Washington

Group Health Classic **Group Health Consumer-Directed Health Plan** **Group Health Value**	Benton Columbia Franklin Grays Harbor (ZIP Codes 98541, 98557, 98559, and 98568) Island King Kitsap Kittitas Lewis Lincoln (ZIP Codes 99008, 99029, 99032, and 99122) Mason	Pierce San Juan Skagit Snohomish Spokane Stevens (ZIP Codes 99013, 99034, 99040, 99110, 99148, and 99173) Thurston Walla Walla Whatcom Whitman Yakima
Kaiser Permanente Classic **Kaiser Permanente Consumer-Directed Health Plan**	Clark Cowlitz Lewis (ZIP Codes 98591, 98593, and 98596) Skamania (ZIP Codes 98639, 98648, and 98671) Wahkiakum (ZIP Codes 98612 and 98647)	
Uniform Medical Plan Classic **UMP Consumer-Directed Health Plan**	Available in all Washington counties and worldwide.	

Blue ink indicates information only for subscribers who have PEBB dental coverage.

Oregon

Group Health Classic **Group Health Consumer-Directed Health Plan** **Group Health Value**	Umatilla (ZIP Codes 97810, 97813, 97835, 97862, 97882, and 97886)
Kaiser Permanente Classic **Kaiser Permanente Consumer-Directed Health Plan**	Benton (ZIP Codes 97330, 97331, 97333, 97339, and 97370) Clackamas (ZIP Codes 97004, 97009, 97011, 97013, 97015, 97017, 97022-23, 97027, 97034-36, 97038, 97042, 97045, 97049, 97055, 97067-68, 97070, 97086, 97089, 97222, and 97267-69 Columbia Hood River (ZIP Code 97014) Linn (ZIP Codes 98321-22, 97335, 97355, 97358, 97360, 97374, and 97389) Marion (ZIP Codes 97002, 97020, 97026, 97032, 97071, 97137, 97301-12, 97314, 97317, 97325, 97342, 97346, 97352, 97362, 97373, 97375, 97381, 97383-85, and 97392) Multnomah Polk Washington Yamhill
Uniform Medical Plan Classic **UMP Consumer-Directed Health Plan**	Available in all Oregon counties and worldwide.

Idaho

Group Health Classic **Group Health Consumer-Directed Health Plan** **Group Health Value**	Kootenai Latah
Uniform Medical Plan Classic **UMP Consumer-Directed Health Plan**	Available in all Idaho counties and worldwide.

2012 Medical Benefits Comparison

The chart below briefly compares the per-visit costs of some in-network benefits for PEBB plans, and extended-network benefits for Group Health's consumer-directed health plan (CDHP). Some copays and coinsurance do not apply until after you have paid your annual deductible. Call the plans directly for more information on specific benefits, including preauthorization requirements and exclusions.

Annual Costs	Group Health				Kaiser Permanente		Uniform Medical Plan	
	Classic	Value	CDHP	CDHP Extended Network[1]	Classic	CDHP	Classic	CDHP
	You pay				You pay		You pay	
Deductible	$250/person $750/family	$350/person $1,050/family	$1,400/individual $2,800/family*		$150/ person $450/family	$1,400/ individual $2,800/family*	$250/person $750/family	$1,400/ individual $2,800/family*
Out-of-pocket maximum	$2,000/ person $4,000/family	$2,000/person $4,000/family	$5,100/individual $10,200/family**		$1,500/person $3,000/ family	$4,200/ individual $8,400/family**	$2,000/person $4,000/family	$4,200/ individual $8,400/family**
Prescription drug deductible	N/A	N/A	N/A		N/A		$100/person $300/family (Tier 2 and 3 drugs)	N/A

*Must meet family deductible before plan pays benefits.
** Must meet family out-of-pocket maximum before plan pays 100% for covered benefits.

Benefits	Group Health				Kaiser Permanente		Uniform Medical Plan	
	Classic	Value	CDHP	CDHP Extended Network[1]	Classic	CDHP	Classic	CDHP
	You pay				You pay		You pay	
Ambulance Per trip, air or ground	20%	20%	10%	30%	15%	15%	20%	20%
Diagnostic tests, laboratory, and x-rays	$0; MRI/ CT/PET scan $30	$0; MRI/ CT/PET scan $40	10%	30%	$10	15%	15%	15%
Durable medical equipment, supplies, and prosthetics	20%	20%	10%	30%	20%	20%	15%	15%
Emergency room (Copay waived if admitted)	$150	$200	10%	30%	$75	15%	$75 copay + 15%	15%
Hearing Routine annual exam	$15	$20	10%	30%	$20	$20	$0	15%
Hardware	Any amount over $800 every 36 months after deductible has been met for hearing aid and rental/repair combined.							
Home health	$0	$0	10%	30%	15%	15%	15%	15%
Hospital services Inpatient	$150/day; $750 maximum/ admission	$200/day; $1,000 maximum/ admission	10%	30%	15%	15%	$200 day; $600 maximum/ year per person + 15% professional fees	15%
Outpatient	$150	$200	10%	30%	15%	15%	15%	15%

The information in this document is accurate at the time of printing. Please contact the plans or review the certificate of coverage before making decisions.

Blue ink indicates information only for subscribers who have PEBB dental coverage.

Benefits	Group Health				Kaiser Permanente		Uniform Medical Plan	
	Classic	Value	CDHP Network	CDHP Extended Network[1]	Classic	CDHP	Classic	CDHP
	You pay				You pay		You pay	
Office visit								
Primary care	$15	$20	10%	30%	$20	$20	15%	15%
Urgent care	$15	$20	10%	30%	$40	$40	15%	15%
Specialist	$30	$40	10%	30%	$30	$30	15%	15%
Mental health	$15	$20	10%	30%	$20	$20	15%	15%
Chemotherapy	$15	$20	10%	30%	$0	$0	15%	15%
Radiation	$30	$40	10%	30%	$0	$0	15%	15%
Physical, occupational and speech therapy (Per visit cost for 60 visits/ year combined)	$15	$20	10%	30%	$30	$30	15%	15%
Prescription drugs								
Retail pharmacy (up to a 30-day supply) Value tier	$5	$5	$5	$5	N/A	N/A	5% (up to $10/ 30-day supply)	15%*
Tier 1	$20	$20	$20	$20	$15	$15	10% (up to $25/ 30-day supply)	
Tier 2	$40	$40	$40	$40	$30	$30	30% (up to $75/ 30-day supply)	
Tier 3	50% up to $250	50% up to $250	50% up to $250	50% up to $250	N/A	N/A	50%*	
Mail order (up to a 90-day supply) Value tier	$10	$10	$10	N/A	N/A	N/A	5% (up to $30/ 90-day supply)	15%*
Tier 1	$40	$40	$40	N/A	$30	$30	10% (up to $75/ 90-day supply)	
Tier 2	$80	$80	$80	N/A	$60	$60	30% (up to $225/ 90-day supply)	
Tier 3	50% up to $750	50% up to $750	50% up to $750	N/A	N/A	N/A	50%* (Specialty drugs up to $150; no limit for non-specialty)	
Preventive care	$0	$0	$0	30%	$0	$0	$0	$0
See certificate of coverage or check with plan for full list of services.								
Spinal manipulations	$15	$20	10%	30%	$30	$30	15%	15%
Vision care Exam (annual)	$15	$20	10%	30%	$20	$20	$0	$0
Glasses and contact lenses	Any amount over $150 every 24 months (or two calendar years for UMP) for frames, lenses, contacts, and fitting fees combined.							

[1] *Group Health's CDHP Extended Network includes First Choice Health Network, Beech Street and its affiliated providers, and any other licensed provider in the U.S.*

UMP members who see an out-of-network provider will pay 40% coinsurance for most services.

*May also be subject to an ancillary charge if drug has an available generic equivalent.

Blue ink indicates information only for subscribers who have PEBB dental coverage.

How the Dental Plans Work

You have three dental plans to choose from:

- **Uniform Dental Plan (preferred provider plan)**
- **DeltaCare (managed-care plan)**
- **Willamette Dental (managed-care plan)**

Uniform Dental Plan (UDP) is a preferred-provider plan administered by Washington Dental Service (WDS). This program provides enrollees with the freedom to choose any dentist, but subscribers receive a higher level of coverage when they receive treatment from dentists who participate in the WDS Delta Dental PPO plan (Group 3000). If you select a dentist who is not a WDS participating dentist, you are responsible for having your dentist complete and sign a claim form.

You can verify that your dentist participates in the Delta Dental PPO network by calling UDP at 1-800-537-3406 or using the search tool online at **www.deltadentalwa.com/pebb**. **Note:** UDP does not mail ID cards but you may download one online.

DeltaCare is also administered by Washington Dental Service (WDS). Under this managed-care plan, you select a primary care dentist from the DeltaCare network. You must confirm that your dentist is in the DeltaCare network (Group 3100) that serves PEBB members and you must receive care from your selected dentist. This is important, as you could be responsible for costs if you receive care from a provider who is not in the DeltaCare network for PEBB members.

You can search for providers on DeltaCare's website at **www.deltadentalwa.com/pebb** using the *Find a Dentist* tool or verify a dentist's participation by calling DeltaCare at 1-800-650-1583.

Willamette Dental, underwritten by Williamette Dental of Washington, Inc., is also a managed-care dental plan. You are required to receive care from Willamette Dental's dentists or specialists.

Willamette Dental may not have providers in all areas. You can find a listing of Willamette Dental providers at **www.WillametteDental.com/WApebb** or by calling Willamette Dental at 1-855-433-6825.

Because dentist and clinic participation with the dental plans can change, please contact the dental plans to verify dentists and clinic locations.

More information on Washington Dental Service

Washington Dental Service (WDS) is a member of the nationwide Delta Dental Plans Association. WDS administers several dental plans, including the Uniform Dental Plan (UDP) and DeltaCare. If you choose UDP or DeltaCare, be sure that you choose a WDS member dentist who participates in your plan's network. Each plan has its own provider network.

Is a managed-care dental plan right for you?

The table on the next page briefly compares the benefits and costs of the UDP and the managed-care dental plans. Before enrolling in a managed-care dental plan, it is important to consider the following:

- Is the dentist I have chosen accepting new patients? (Remember to identify yourself as a PEBB member.)
- Am I willing to travel for services if I select a dentist in another service area?
- Do I understand that all dental care is managed through my primary care dentist or network provider, and I cannot self-refer for specialty care?

If you are receiving continuous dental treatment (such as orthodontia) and are considering changing plans, contact the plans directly to find out if their plan will cover your continuous dental treatment.

Dental Benefits Comparison

For information on specific benefits and exclusions, refer to the dental plan's certificate of coverage or contact the dental plans directly.

Annual Costs	Uniform Dental Plan (preferred-provider organization)	• DeltaCare • Willamette Dental (managed-care dental plans)
	You pay	You pay
Annual deductible	$50/person, $150/family	$0
Annual maximum	Amounts over $1,750; orthodontia, nonsurgical TMJ, and orthognathic surgery have specific coverage maximums	No general plan maximum; nonsurgical TMJ and orthognathic surgery have specific coverage maximums

Benefits	Uniform Dental Plan (preferred-provider organization)	• DeltaCare • Willamette Dental (managed-care dental plans)
	You pay	You pay
Dentures	50% PPO and out of state; 60% non-PPO	$140 for complete upper or lower
Endodontics (root canals)	20% PPO and out of state; 30% non-PPO	$100 to $150
Nonsurgical TMJ	30% of costs up to$500 for PPO, out of state, or non-PPO; then any amount over $500 in member's lifetime	DeltaCare: 30% of costs up to $1,000/year; then any amount over $5,000 in member's lifetime Willamette Dental: Any amount over $1,000 per year and $5,000 in member's lifetime
Oral surgery	20% PPO and out of state; 30% non-PPO	$10 to $50 to extract erupted teeth
Orthodontia	50% of costs up to $1,750 for PPO, out of state, or non-PPO, then any amount over $1,750 in member's lifetime	Up to $1,500 per case
Orthognathic surgery	30% of costs up to $5,000 for PPO, out of state, or non-PPO; then any amount over $5,000 in member's lifetime	30% of costs up to $5,000; then any amount over $5,000 in member's lifetime
Periodontic services	20% PPO and out of state; 30% non-PPO	$15 to $100
Preventive/diagnostic	$0 PPO; 10% out of state; 20% non-PPO	$0
Restorative crowns	50% PPO and out of state; 60% non-PPO	$100 to $175
Restorative fillings	20% PPO and out of state; 30% non-PPO	$10 to $50

Blue ink indicates information only for subscribers who have PEBB dental coverage.

Life and AD&D Insurance

Your life insurance benefits include six options to allow you to cover yourself, your spouse or Washington State-registered domestic partner, and your children. As an employee, your basic life insurance covers you and pays your designated beneficiaries in the event of your death. Accidental death and dismemberment (AD&D) insurance provides extra benefits for certain injuries or death resulting from an accident.

Life and AD&D insurance is available to PEBB benefits-eligible state and higher-education employees, as well as employees who work for a K-12 school district, educational service district, or employer group that offers both PEBB medical and dental coverage.

What life and AD&D insurance does PEBB offer?

PEBB offers $25,000 of basic life insurance and $5,000 basic AD&D insurance (called **Basic Life and AD&D Insurance for Employees**) as part of your benefits package, at no cost to you.

In addition, PEBB offers optional life insurance for you to purchase:

- **Supplemental Life Insurance for Employees:** You may apply for additional amounts in $10,000 increments from $10,000 to $750,000. Supplemental Life Insurance for Employees covers death from any cause.
- **Basic Dependent Life Insurance:** $2,500 for your spouse or Washington State-registered domestic partner, and $2,500 for each dependent child. Covers death from any cause. You pay $0.50 per family per month, regardless of the number of dependents.
- **Supplemental Spouse Life Insurance:** If you enroll your spouse or Washington State-registered domestic partner in Basic Dependent Life Insurance, you may apply for additional amounts of Supplemental Spouse Life Insurance in $5,000 increments (up to one-half of the amount of Supplemental Life Insurance you obtain for yourself). Supplemental Spouse Life Insurance covers death from any cause.
- **Supplemental Employee AD&D Insurance:** You may enroll in Supplemental AD&D coverage in multiples of $25,000 ($25,000 minimum) up to $250,000 for accidental death and dismemberment. Supplemental Employee AD&D Insurance does not cover death and dismemberment from other causes.

* **Supplemental Dependents' AD&D Insurance:** If you select Supplemental Dependents' AD&D Insurance in addition to your own, your spouse or Washington State-registered domestic partner will be insured for 50% of your benefit if you have no dependent children. If you have children, your spouse or partner will be insured for 40% and each dependent child for 5% of your benefit. If you have no spouse or partner, each dependent child will be insured for 10% of your benefit. This dependent coverage does not reduce your coverage.

When can I enroll?

You may enroll **no later than 60 days** after becoming eligible for PEBB benefits (generally your first day of employment) for the following coverage, without providing evidence of insurability:

- Supplemental Life Insurance for Employees up to $250,000 (if you are under age 60) or up to $100,000 (if you are age 60 or older)
- Basic Dependent Life Insurance
- Supplemental Spouse Life Insurance (up to $50,000)
- Supplemental Employee AD&D Insurance

Supplemental Dependents' AD&D Insurance does not require evidence of insurability.

You must provide evidence of insurability to ReliaStar Life if you:

- Apply **after 60 days** of your initial eligibility.
- Request more than $50,000 in Supplemental Spouse Life Insurance.
- Request more than $250,000 (if under age 60) or more than $100,000 (if age 60 or older) in Supplemental Life Insurance for Employees.

ReliaStar Life must approve your request before you will have coverage.

Blue ink indicates information only for subscribers who have PEBB dental coverage.

How do I enroll?

Complete and submit the *Life and AD&D Insurance Enrollment/ Change Form* (found in the back of this booklet) to your employer's personnel, payroll, or benefits office. If applying for Supplemental Spouse Life Insurance or Supplemental Life Insurance for Employees that requires evidence of insurability, you must also complete the *Life Insurance Evidence of Insurability Form* (found on PEBB's website at **www.pebb.hca.wa.gov** under *Forms).*

For questions about enrollment, contact your employer's personnel, payroll, or benefits office. If you need additional information, contact ReliaStar Life Insurance Company at 1-866-689-6990.

PEBB group term life insurance coverage is offered through ReliaStar Life Insurance Company, a member of the ING family of companies (Policy Form #LP00GP). This is a summary. To see the certificate of coverage or to get forms, either:

- Go to **www.pebb.hca.wa.gov,** select *Publications* (for the certificate of coverage) or *Forms*; or
- Contact your employer's personnel, payroll, or benefits office.

Premium rates

Supplemental Life Insurance for Employees and Supplemental Spouse Life Insurance

	COST PER $1,000 PER MONTH	
Age	Non-smoker	Smoker
Less than 25	$0.024	$0.031
25–29	0.026	0.037
30–34	0.029	0.049
35–39	0.036	0.056
40–44	0.054	0.063
45–49	0.078	0.095
50–54	0.122	0.145
55–59	0.228	0.270
60–64	0.350	0.411
65–69	0.646	0.792
70+	0.964	1.287

Your premium rate changes to the next higher rate as you reach each new age bracket.

Supplemental Accidental Death and Dismemberment Insurance

			Coverage your spouse or Washington state-registered domestic partner would have		Coverage your children would have	
Employee AD&D benefit	Cost to cover only yourself	Cost to cover you & your dependents	With no children	With children	If you have a spouse or Washington state-registered domestic partner	If you have no spouse or Washington state-registered domestic partner
$ 25,000	$0.20	$0.30	$12,500	$10,000	$1,250	$2,500
50,000	0.40	0.60	25,000	20,000	2,500	5,000
75,000	0.60	0.90	37,500	30,000	3,750	7,500
100,000	0.80	1.20	50,000	40,000	5,000	10,000
125,000	1.00	1.50	62,500	50,000	6,250	12,500
150,000	1.20	1.80	75,000	60,000	7,500	15,000
175,000	1.40	2.10	87,500	70,000	8,750	17,500
200,000	1.60	2.40	100,000	80,000	10,000	20,000
225,000	1.80	2.70	112,500	90,000	11,250	22,500
250,000	2.00	3.00	125,000	100,000	12,500	25,000

Rates shown are guaranteed through January 1, 2013.

Long-Term Disability Insurance

Long-term disability (LTD) insurance is designed to help protect you from the financial risk of lost earnings due to serious injury or illness. When you enroll in LTD coverage, it pays a percentage of your monthly earnings to you if you become disabled.

LTD insurance is available to PEBB benefits-eligible state and higher-education employees, and employees who work for a K-12 school district, educational service district, or employer group that offers both PEBB medical and dental coverage. **Exceptions:** Optional LTD insurance is not available to seasonal employees who work a season that is less than nine months, or port commissioners.

What long-term disability insurance does PEBB offer?

LTD coverage has two parts:

1. **Basic LTD Plan** is provided by PEBB as part of your benefits package, at no cost to you.
2. **Optional LTD Plan** is available for you to purchase.

LTD benefits amounts

The monthly LTD benefit is a percentage of your insured monthly Predisability Earnings, reduced by deductible income (such as work earnings, workers' compensation, sick pay, Social Security, etc.).

The LTD benefit for each plan is shown below:

	Basic LTD	Optional LTD
% of monthly predisability earnings the plan pays	60% of the first $400	60% of the first $10,000
Minimum monthly LTD benefit	$50	$50
Maximum monthly LTD benefit	$240	$6,000

Waiting period before benefits become payable

Basic LTD Plan: 90 days or the period of sick leave (excluding shared leave) for which you are eligible under the employer's sick leave plan, whichever is longer.

Optional LTD Plan: 30, 60, 90, 120, 180, 240, 300, or 360 days (depending on your election), or the period of sick leave (excluding shared leave) for which you qualify under the employer's sick leave, whichever is longer.

What is considered a disability?

Being unable to perform with reasonable continuity the duties of your **Own Occupation** as a result of sickness, injury, or pregnancy during the benefit waiting period and the first 24 months for which LTD benefits are payable.

After that, being unable to perform with reasonable continuity the Material Duties of **Any Occupation** for which you are reasonably able through education, training, or experience as a result of sickness, injury, or pregnancy. During this period, you are considered Partially Disabled if you are working, but unable to earn more than 60% of your indexed Predisability Earnings as a result of sickness, injury, or pregnancy.

Maximum benefit period

For both Basic LTD and Optional LTD coverage, the benefit duration is based on your age when the disability begins.

Age	Maximum benefit period
61 or younger	To age 65, but not less than 42 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

Blue ink indicates information only for subscribers who have PEBB dental coverage.

How much does the Optional Plan cost?

Payroll deduction as a percentage of Predisability Earnings

Benefit waiting period	Higher-education retirement plan employees	TRS, PERS, and other retirement plan employees
30 days	1.86%	1.47%
60 days	0.95%	0.78%
90 days	0.52%	0.43%
120 days	0.30%	0.26%
180 days	0.23%	0.20%
240 days	0.22%	0.20%
300 days	0.20%	0.18%
360 days	0.20%	0.17%

Multiply your monthly base pay (up to $10,000) by the percentage shown above for the desired Benefit Waiting period to calculate your Optional LTD monthly premium.

When can I enroll?

You may enroll in basic and optional LTD coverage **no later than 31 days** after becoming eligible for PEBB benefits (generally your first day of employment).

If you apply for optional LTD coverage **after 31 days**, or decrease the waiting period for optional LTD coverage, you must provide evidence of insurability and your Evidence of Insurability must be approved by Standard Insurance Company before your insurance becomes effective.

How do I enroll?

If applying within 31 days of initial eligibility for PEBB benefits, complete and submit the *Long Term Disability (LTD) Enrollment/Change Form* (found in the back of this booklet) to your employer's personnel, payroll, or benefits office.

If applying after 31 days, or decreasing the waiting period for optional LTD coverage, you must also complete the *Long Term Disability (LTD) Evidence of Insurability Form* (found at **www.pebb.hca.wa.gov** under *Forms*) and submit it to Standard Insurance Company.

For questions about enrollment, contact your employer's personnel, payroll, or benefits office. If you need additional information, contact Standard Insurance Company at 1-800-368-2860.

PEBB's long-term disability (LTD) insurance coverage is offered through Standard Insurance Company. This is a summary. To see the certificate of coverage or to get forms, you can do one of the following:

- **Go to www.pebb.hca.wa.gov, select *Publications* (for the certificate of coverage) or *Forms*.**
- **Contact your employer's personnel, payroll, or benefits office.**

FSA and DCAP

Enrolling in a Flexible Spending Account

The PEBB Program offers a medical flexible spending account (FSA) that allows you to set aside money from each paycheck—before taxes—to pay for out-of-pocket health expenses. This reduces both your annual taxable income and the amount you pay for out-of-pocket health expenses. This is only offered to PEBB benefits-eligible state and higher-education employees.

To set up an FSA, you can enroll at the following times:

- When you become eligible for PEBB benefits. You must enroll **no later than 31 days** after you become eligible (usually on your first day of employment). See WAC 182-08-197 for details.
- During the PEBB annual open enrollment.
- During the plan year if you or an eligible family member has a qualifying event that creates a special open enrollment. You must enroll **no later than 60 days** after the event that created the special open enrollment. See WAC 182-08-199 for details or see the *FSA Enrollment Guide* at **http://pebb.asiflex.com**.

You decide how much you want to contribute per pay period when you enroll. The minimum annual contribution is $240; the maximum is $3,600.

The full amount of your calendar year FSA contribution is available on your first day of coverage for expenses incurred that day forward. You may use your FSA to reimburse yourself for out-of-pocket medical, dental, and vision expenses allowed by the Internal Revenue Service (IRS). You may not pay premiums from your account, but you can use it for deductibles, copays, and coinsurance. Your and your family members' expenses (those who qualify as dependents under IRS rules) may be reimbursed from your account.

Enrolling in the Dependent Care Assistance Program

The Dependent Care Assistance Program (DCAP) offers you an opportunity to reduce taxable income by setting aside money from each paycheck—before taxes—to pay for dependent care expenses. DCAP reimburses qualified dependent care expenses that allow you and your spouse (if married) to attend school, work, or look for work. If you have a stay-at-home spouse, you cannot enroll in the DCAP. This benefit is only offered to PEBB benefits-eligible state and higher-education employees.

Qualifying dependents include:

- A dependent under age 13 who qualifies as an Internal Revenue Service (IRS) dependent.
- A spouse who is physically and/or mentally incapable of self-care.
- Any other IRS-recognized dependent who is physically and/or mentally incapable of self-care.

To set up a DCAP account, you can enroll at the following times:

- When you become eligible for PEBB benefits. You must enroll **no later than 31 days** after you become eligible (usually on your first day of employment). See WAC 182-08-197 for details.
- During the PEBB annual open enrollment.
- During the plan year if you or an eligible family member has a qualifying event that creates a special open enrollment. You must enroll **no later than 60 days** after the event that created the special open enrollment. See WAC 182-08-199 for details or see the *DCAP Summary* at **http://pebb.asiflex.com**.

You decide how much you want to set aside per pay period when you enroll. The maximum is $5,000 per household on the total amount of tax-free dependent care assistance that you can receive in any year ($2,500 if you and your spouse file separate tax returns).

Application Software, Inc. (ASIFlex) administers the FSA and DCAP

For more information and forms, go to ASIFlex's website at **http://pebb.asiflex.com** or call ASIFlex at 1-800-659-3035. Send questions via email at **asi@asiflex.com**.

Blue ink indicates information only for subscribers who have PEBB dental coverage.

Long-Term Care Insurance

The PEBB Program sponsors a voluntary group long-term care insurance plan for:

- Employees who are eligible for PEBB benefits.
- Retirees who are eligible for PEBB benefits.
- Spouses and Washington State-registered domestic partners (including surviving spouses of eligible employees).
- Parents and parents-in-law (under issue age 80) of eligible employees.

John Hancock Life Insurance Company (U.S.A.) administers the group long-term care insurance plan.

Family members must be issue age 18 or older to apply for coverage. All applicants must reside in the U.S. (50 states and District of Columbia) on the date they apply and the coverage effective date. This does not apply to employees and their spouses or Washington State-registered domestic partners temporarily residing outside of the U.S. applying with their U.S. residence address. (All certificates will be mailed to a U.S. address.)

Why should I enroll in long-term care?

The need for long-term care can occur at any point during your life due to illness, accident, or the effects of aging.

Long-term care insurance covers services at home, in a nursing home setting, and other types of facilities. The mix of care settings and levels of care varies with different policies.

Who helps coordinate what type of care is needed?

John Hancock's care coordinators are registered nurses or licensed social workers who are knowledgeable in long-term care. They will work with you and your family to find the care that is right for you and help you use your long-term care benefits wisely. However, you are not required to follow their recommendations.

What are some features of the long-term care insurance plan?

- **Premiums are based on your age at the time of enrollment**—Your age when you enroll determines your monthly premium rate. The younger you are when you enroll, the lower your cost will be.
- **Inflation protection feature**—This allows you to increase your coverage periodically, so that it keeps pace with inflation. You can choose to accept or decline each inflation addition offer, allowing you to determine how much coverage you need.
- **Easy premium payment methods**—You have the option to pay premiums through direct billing or automatic bank withdrawal.
- **Full portability of coverage**—Even if you leave your job and are no longer eligible for PEBB benefits, you can continue your coverage at group rates.

When can I enroll?

If you are a new employee applying **within 31 days** after you become eligible for PEBB benefits (this is generally your first day of employment), you will have guaranteed acceptance into the plan, regardless of your current health status. This offer of guaranteed acceptance is not an annual opportunity. If you and your eligible family members apply for coverage **after 31 days**, you and your family members must provide proof of good health and be approved for coverage to enroll in long-term care insurance.

How do I enroll?

To request an enrollment kit from John Hancock Life Insurance Company, you can either:

- Visit PEBB's group long-term care website at **http://pebbltc.jhancock.com** (user name: pebbltc password: jhancock), or
- Call John Hancock Life Insurance Company (U.S.A) at 1-800-399-7271.

This is only a brief summary of some of the features of the PEBB group long-term care insurance plan. Some plan features vary by state. More details about plan provisions and exclusions are provided in the long-term care enrollment kit.

Auto and Home Insurance

The PEBB Program offers voluntary group auto and home insurance through its alliance with Liberty Mutual Insurance Company—one of the largest property and casualty insurance providers in the country.

What does Liberty Mutual offer?

For PEBB members, this means a group discount of up to 12% off Liberty Mutual's auto and home insurance rates. This is possible through Liberty Mutual's Group Savings Plus—a program that provides an exclusive group discount to members. In addition to the discount, Liberty Mutual also offers:

- **Convenient payment plans**—including automatic payroll deduction (for employees), electronic funds transfer, or direct billing at home.
- **Claims service**—24 hours a day, 7 days a week.
- **New car replacement coverage**—applies to a total covered loss on a car less than one year old, not previously owned, with less than 15,000 miles (annual deductible applies).
- **Individualized service from local representatives** (see box).
- **A guaranteed rate for 12 months.**

When can I enroll?

You can choose to enroll in auto and home insurance coverage at any time.

How do I enroll?

To request a quote for auto or home insurance, you can contact Liberty Mutual one of three ways (be sure to have your current policy handy):

- Visit PEBB's website at **www.pebb.hca.wa.gov** and select *Benefits*, then *Auto/home insurance*.
- Call Liberty Mutual at 1-800-706-5525. Be sure to mention that you are a State of Washington PEBB member.
- Call or visit one of the local offices (see box).

If you are already a Liberty Mutual policyholder and would like to save with Group Savings Plus, just call one of the local offices to find out how they can convert your policy at your next renewal.

Note: Liberty Mutual does not guarantee the lowest rate to all PEBB members; rates are based on underwriting for each individual situation. Discounts and savings are available where state laws and regulations allow, and may vary by state. To the extent permitted by law, applicants are individually underwritten; not all applicants may qualify.

Contact a local Liberty Mutual office (mention client #8246):

Bellevue **1-800-253-5602**
13555 SE 36th St, Suite 360

Bothell **1-800-821-3895**
18323 Bothell-Everett Hwy, Suite 345

Federal Way **1-800-826-9183**
930 S. 336th St., Suite C

Portland **1-800-248-8320**
One Liberty Centre

Spokane **1-800-208-3044**
11707 East Sprague Ave., Suite 205

Tukwila **1-800-922-7013**
14900 Interurban Ave. S., Suite 142

Tumwater **1-800-319-6523**
300 Deschutes Way SW, Suite 210

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Enrollment Forms

The following forms are available online:

2011 Employee Enrollment/Change

http://www.pebb.hca.wa.gov/documents/forms/2012/50-400.pdf

2011 Employee Enrollment/Change for Medical Only Groups

http://www.pebb.hca.wa.gov/documents/forms/2012/52-030.pdf

Life Insurance Enrollment Form

http://www.pebb.hca.wa.gov/documents/forms/2012/50-402.pdf

Long Term Disability (LTD) Enrollment/Change Form

http://www.pebb.hca.wa.gov/documents/forms/2012/50-404.pdf

Valid dependent verification documents

Use the list below to determine which verification document(s) to submit with your enrollment form. You may submit one copy of your tax return if it includes all family members that require verification, such as your spouse and children.

Documents for a spouse (choose one option):

- Copy of page 1 of last year's *Married Filing Jointly* federal tax return that lists your spouse *(you may black out financial information)*
- Copy of page 1 of last year's *Married Filing Separately* federal tax return for both subscriber and spouse that lists your spouse *(you may black out financial information)*
- Copy of marriage certificate only (for a marriage that occurred within the last 60 days)
- Copy of marriage certificate **and** proof of shared residence (such as a utility bill)
- Copy of marriage certificate **and** proof of shared financial accounts, (such as a bank statement *(you may black out financial information)*
- Copy of petition for dissolution of marriage
- Copy of legal separation notice, signed by a court officer
- Copy of Defense Enrollment Eligibility Reporting System (DEERS) registration

Document for a Washington State-registered domestic partner:

Copy of registered domestic partnership card or certificate, issued by the Washington Secretary of State's Office

Documents for children (choose one option):

- Copy of page 1 of last year's federal tax return that lists your child as a dependent and listed as son or daughter *(you may black out financial information)*
- Copy of a birth certificate (or hospital certificate with the child's footprints on it) showing name of parent who is the subscriber, the subscriber's verified spouse, or the subscriber's verified Washington State-registered or qualified domestic partner
- Copy of a certificate or decree of adoption
- Copy of a court-ordered parenting plan
- Copy of a Qualified Medical Support Order
- Copy of Defense Enrollment Eligibility Reporting System (DEERS) registration

Washington State
Health Care Authority
Public Employees Benefits Board

P.O. Box 42684
Olympia, WA 98504
HCA 50-100 (11/11)